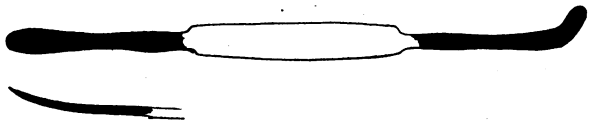
exist. That the sound can be used the first or second month without producing an abortion, there is no doubt. In the later months naturally the sound would not slip in without interfering with the connections between the membranes.

A SIMPLE TONSIL DISSECTOR.*

By PERCY SUMNER, M. D., San Francisco.

Nothing original is claimed for the instrument presented—it is simply an adaptation from other instruments, making, I believe, an excellent instrument for the removal of the tonsils.

Ten or twelve years ago the surgeons of London, England, were enucleating tonsils with the finger, a method that is advocated to-day by some surgeons; but I think most of us are agreed that it is better and cleaner to use an instrument for that purpose, when that instrument will do all that the finger does, and more. This idea of using an instrument is shown by the Schmidt Pillar Splitter, and later by the tonsil dissector of Yankauer. The former is excellent but not sufficient for all purposes; the latter is so large that I have found when placed in a small mouth the operator cannot see what he is doing. The first essential about any instrument used in the throat is that it shall be so shaped that it will not interfere with the view of the surgeon, and this instrument fills that requirement exactly. The second important consideration is to combine as much as possible in one instrument a number of features so that it will be necessary to use only a few instruments; and the shape of this instrument makes it possible to do things for which one usually needs extra instruments.



The instrument is patterned on the style of the Allis Dry Dissector. Dr. F. J. S. Conlan of this city had been using this instrument for dissecting tonsils, and when I saw it I felt the possibilities in it. The hook part of the instrument was made thinner and lengthened, and the other end in addition to being lengthened and made thinner was given a curve similar to a pair of curved scissors that I had been accustomed to using for the operation.

The instrument has now been used on a large number of patients with excellent results, and I do not see at present how it can be improved. It is so made that one has an uninterrupted view of the field of operation, a matter of great importance in a child's throat, and the two ends curved on the side and on the flat make it possible to dispense with all other dissectors.

My method of doing the operation is to cut the mucous membrane over the anterior pillar from the tongue around to the posterior pillar with a sharp knife (the knife I find best for this purpose being the Douglass Crypt Knife, with the blunt point ground off, which gives a sharp razor edge that cuts readily into the mucous membrane, and with the dissector the posterior pillar is easily torn through and the adhesions severed enabling one to apply the snare over a tonsil that is free excepting the attachment at the base.

I am indebted to Dr. F. J. S. Conlan for first seeing him use the Allis Dry Dissector for tonsil work and for the many suggestions he has made during the time that I have been perfecting my tonsil dissector.

The instrument is made by H. Weniger, 244 Ash avenue, San Francisco.

REPORT OF A CASE OF THROMBOSIS OF THE CENTRAL RETINAL VEIN.*

By E. W. ALEXANDER, M. D., San Francisco, Calif.

The appearance of thrombosis of the central retinal vessels suggests in most cases a widespread pathological condition of the vascular system, and from such a standpoint I report the following case:

The pathology and etiology of this condition are subjects which are still disputed, partly because of the infrequency of the condition, and partly because it is seldom that one has the opportunity to examine such eyes anatomically soon enough after the onset to be sure that he is studying the primary and not the secondary lesions, which are so frequently associated.

As evidence of the variety of pathological findings offered in explanation of thrombosis of the central retinal vein I will quote from Parsons' "Pathology of the Eye": "(1) Thrombus of the vein, (2) occlusion of the vein by proliferation of the intima but without thrombosis, (3) multiple thrombi in the retinal veins, but without a thrombus in the central vein, (4) multiple emboli or perhaps thrombi in the retinal arteries, (5) changes in the retinal vessels sometimes amounting to occlusion but not the result of either thrombosis or embolism, (6) hemorrhage into the substance of the optic nerve." Such a variety of findings seem to point to one of two facts, viz.: that the etiology cannot be founded on any one circumstance, or that the clinical picture is symptomatic of several pathological changes.

In answer to the question "What general and local conditions favor the occurrence of thrombosis of the central vein?" Parsons states that chief among the causes of thrombosis of the central vein must undoubtedly be counted angio-sclerosis. But we must consider as well the broad principles of thrombosis which are interesting even if largely theoretical. There are certain biochemical agents which play a varying role: certain substances in the blood which favor coagulation such as thrombokinase, calcium, salts, etc.; again the chemical activities may be the result of bacterial growth such as typhoid, lobar pneumonia, plague, hog cholera and diphtheria, which favor the formation of hemoglutinins. The same is true of intoxications from vegetable poisons, rioni, tetanus, etc.; also eclampsia and carbolic acid poisoning; and, finally certain forms of toxic processes associated with blood destruction. From a mechanical standpoint the factors

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